CONSENT TO RELEASE HEALTH INFORMATION

THE UNIVERSITY OF IOWA
COLLEGE OF DENTISTRY
& DENTAL CLINICS

Please PRINT (except signatures) and provide complete answers (and addresses) in each section.

SECTION A: PATIENT GIVING AUTHORIZATION

Name: _____ Axium #: _____

Address: _____

Telephone: _____ E-mail: _____

Date of Birth _____ Last 4 digits of Social Security #: _____

Will the patient be returning to the College of Dentistry for further dental treatment? ____Yes _____ No _____ Maybe

SECTION B: INFORMATION REQUESTED

Please be aware that the dental record may contain sensitive material. You have the option of us sending the copy of your record directly to you.

- ❑ Radiographs (X-rays)
- ❑ Progress Notes (Visit Information)

_____

Send to: _____ Phone #: _____

Select only one option below

❑ Email	$10	Email Address _____
❑ Mail	$20	Mail Address_____
		_____
❑ Fax (Progress notes only)	$10	Fax Number_____

SECTION C: EXPIRATION and REVOCATION

This authorization will automatically expire one year from the date of signature, except as specified: _____
Date

At that time, no express revocation shall be needed to terminate my consent, but understand that I may revoke this consent at any time by sending a written notice to the **Central Records, The University of Iowa College of Dentistry, 203 DSB North, Iowa City, Iowa 52242-1001**. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting the Central Records, The University of Iowa College of Dentistry, 203 DSB North Iowa City, Iowa 52242-1001.

SECTION D: PATIENT'S SIGNATURE

I, the undersigned, hereby authorize The University of Iowa College of Dentistry to release dental information concerning the above patient:

_____ _____
Signature of Patient or Legal Guardian Date

_____
Address City State ZIP

_____
Relationship, if NOT the Patient